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The Rural Homeless

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C The Rural Homeless

Larry T. Patton

Homelessness is a reality for a growing number of rural Americans. This situation has received little notice, as media and research attention has focused on the highly visible problem of the urban homeless. This lack of public recognition is hardly surprising. Rural residents have a long tradition of preferring self-help and reliance on relatives, friends, and neighbors to taxpayer-supported programs, which has effectively disguised the magnitude of the problem of rural homelessness. Some would even argue that while private, voluntary action was meeting the need, the policy implications of ignoring the rural homeless were minimal.

The situation appears to be changing, however. There are growing indications that some rural communities can no longer shoulder the burden alone. Informal community support networks are being overwhelmed by the severity and duration of the rural economic crisis. Farm communities, in particular, are experiencing an erosion of the old rural ethic that "we take care of our own," a development that appears to be independent of the rural economic crisis.

At this point, there are no answers to many questions central to the public policy debate: issues of definition, the prevalence of rural homelessness, changes in its incidence, and similarities and differences between rural and urban homeless populations. Unfortunately, this appendix cannot authoritatively resolve these questions; that will require substantial additional field research. The discussion presented here relies instead on a review of the meager available research, a special survey conducted

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by the U.S. Department of Health and Human Services (HHS) of its community health center grantees, and two site visits—to the Black Belt counties of Alabama and Mississippi and the farm regions of Minnesota and North Dakota—that were supported by HHS. While broad generalizations cannot be drawn from the site visits, they proved particularly useful in providing sharply contrasting views of homelessness.

This appendix first examines the nature and causes of homelessness in rural areas. The structural transformation now under way in the rural economy, the nature of the rural environment, and rural social service networks are briefly reviewed, as is the available evidence regarding the characteristics of the rural homeless.

The remainder of the appendix examines the scanty data on medical care utilization by the homeless. The primary sources of data include a study supported by the National Institute of Mental Health of the homeless in Ohio and the community health center survey and site visits mentioned above.

This appendix offers a number of observations:

- Rural homelessness is essentially an economic problem. The failure of policymakers to appreciate the extent of the rural economic crisis, and the degree to which a majority of rural counties are especially vulnerable, has contributed to the tendency to perceive homelessness exclusively as an urban problem.
- The nature of rural communities obscures the problem of homelessness as well. With the exception of larger, more urbanized cities, rural communities seldom have in place a formal social service network that would permit the transient homeless to gather or be counted. In fact, they are often met with hostility and suspicion by community residents.
- The willingness of neighbors to "take care of their own," shuttling the economically distressed family from neighbor to neighbor, has been a major factor leading to underestimates of the rural homeless. The site visits also highlighted the significant private efforts being made by philanthropic and religious organizations to assist the homeless.
- The duration and the pervasiveness of the economic crisis may increase the public burden of rural homelessness. An important finding in farming communities is the growing evidence that those in economic distress can no longer rely on their neighbors for help.
- The rural homeless appear to be slightly younger than their urban counterparts and more likely to be living in intact, two-parent families in which both parents were recently employed before being forced into poverty and homelessness.
- The ability to access medical care in times of emergency appears adequate, but this finding is tentative at best. There are few data on the

homeless living in the sparsely populated areas where provider shortages would be more common.

- Routine or preventive care is used little, if at all, which is similar to the case for the urban homeless. The high prevalence of chronic disease in the rural population and the high rates of malnutrition, dental disease, and environmental hazards (poor sanitation, inadequate and dangerous housing, and contaminated water supplies) suggest the importance of access to such care.
- There is a great need to better utilize the existing delivery systems, such as community, rural, and migrant health care centers, to address the medical care needs of the rural homeless.

A final point deserves to be mentioned: the issue of relative burden. Compared to urban America, there are great differences in the scale, density, and resource base of rural communities that severely limit the ability of these communities to assist individuals in economic distress. That perspective is essential to keep in mind as we develop better estimates of the relative distribution of the homeless in rural and urban communities. Even relatively low numbers of homeless individuals and families can easily overwhelm a rural community's resources.

THE RURAL ECONOMIC CRISIS

Parts of rural America are facing their worst economic crisis since the Great Depression. In the last few years, the rural economy has been dealt a series of economic setbacks.

- Farm foreclosures have been taking place at a staggering rate: 650,000 foreclosures have occurred since 1981 and another 2,000 farmers give up farming each week.
- Low-wage, labor-intensive rural manufacturing has lost over half a million jobs since 1981 as a result of foreign competition.
- Timber, mining, petroleum, and other energy industries experienced severe downturns as energy prices tumbled (Sinclair, 1987; Brown and Deavers, no date).

The secondary effects have been just as severe. It is estimated that one business fails for each six to seven farms lost to foreclosure (Ranney, 1986); in fact, in 1985, 130 banks closed, the highest number in any year since the Great Depression (U.S. Congress, Senate, Committee on Governmental Affairs, 1986). The rural unemployment rate now consistently exceeds the urban unemployment rate, a reversal of the historical

trend. In addition, the rural poverty rate approached the 20 percent mark, the highest level in two decades (Brown and Deavers, no date).

Yet the impact of these economic changes on rural counties has been uneven: Some rural counties have experienced few repercussions from the worsening economic climate; others have been devastated. Two aspects of the rural economy are useful in identifying those rural counties most at risk.

First, most rural counties have never successfully diversified their economic base. As a result, the economies of two out of every three nonmetropolitan counties are dominated by a single industry. In 1985, of the 2,443 nonmetropolitan counties, 29 percent (702 counties) were primarily dependent on agriculture, 28 percent (678 counties) were manufacturing dependent, and 8 percent (200 counties) were mining dependent (Brown and Deavers, no date).* All of these industries are in financial distress.

Second, while poverty has left few rural counties untouched, rural poverty has always been extremely concentrated. Two-thirds of the rural poor reside in the southeastern states, as do 93 percent of rural blacks (Ghelfi, 1986; National Association of Community Health Centers, 1987). Of the 231 counties that have ranked in the bottom fifth of income for the past 30 years, all but 18 are located in the southeastern United States. In fact, four states (Georgia, Kentucky, Mississippi, and Tennessee) each had more than 20 such counties. The 18 persistently poor counties outside the South were all minority dominated (Hoppe, 1985).

Counties whose economies are dominated by a single industry in distress—particularly those plagued by persistent poverty—offer displaced workers few job alternatives. Unfortunately, there is little basis on which to predict whether rural displaced workers will migrate to metropolitan areas, where some may contribute to the urban homeless problem, or remain in rural areas. While there is now under way a net migration away from rural areas (Sinclair, 1987), migration clearly works in both directions. Migrant laborers; those alienated from urban life; unsuccessful job seekers in urban areas returning to their families; and even those accidentally stranded in their job searches due to emotional, financial, or physical collapse all contribute to migration into rural areas (Frank and Streeter, 1987). In addition, the rapid rise in the poverty and unemployment rates in rural areas demonstrates that many rural residents have chosen to remain, despite the low probability of finding alternative employment above the minimum wage.

*A county is viewed as being dependent on a specific industry when the weighted average annual income of the industry accounts for 20 percent or more of weighted annual total labor and proprietor income, according to Brown and Deavers (no date).

DEFINING RURAL HOMELESSNESS

The impediments to establishing a clear-cut definition of homelessness in urban areas are only exacerbated in rural America. Clearly, all displaced workers or farmers do not always join the ranks of the homeless; many do not even make it into the official unemployment count.

How then do we define those who are homeless in rural areas? Do we include those in substandard housing? How do we treat those living with friends and relatives? Do we exclude those who pay nominal rents? At what point does a temporary housing arrangement become permanent? The following case highlights this dilemma:

> Family of three (elderly woman, adult daughter, infant grandchild) living in two-room shack (family home for over 20 years on relatives' property in rural area); approximate dimensions, 12 by 20 feet. No electricity, water, or septic tank. Shack is located in area of water runoff and floor is wet most of the year. (Household) head receives disability (Supplemental Security Income), adult woman works minimum-wage job. Rent is $40/month. Water is carried one-half mile from church spigot; has privy. Has been on waiting list 2 years for Section 8 (housing); list is 4 years long. House cannot be winterized due to size and placement of wood stoves, it is felt that making the house weathertight would increase danger of fire. No available affordable housing for this family at this time.

This example was volunteered by a Community Action Agency director as a portrait of their "typical" homelessness case, and it is very compelling.* But elements of this profile are unsettling: Is this family truly homeless? The literature review and the site visits did not provide an operational definition of rural homelessness, but they did provide a general framework for approaching the question.

First, there is little disagreement that those without any form of shelter are homeless; the critical question is the extent to which any definition includes those who are temporarily housed as well. In urban areas, researchers have the option of including selective groups of people with temporary housing, such as the portion of the homeless served by shelters. In truly rural areas, such an option is unavailable because formal services such as shelters are virtually nonexistent; residents who become homeless must rely on friends, neighbors, and relatives for temporary housing.

A relative or friend will often bear the burden alone, initially; later, sharing responsibility by "shuttling the person (or family) along from

*This was one Community Action Agency director's response to a survey being conducted by the Housing Assistance Council (1984) of Washington, D.C. The survey was not complete when this report was drafted.

family to family as their 'welcome' is exhausted" (Ohio Department of Mental Health, 1985). Data on rural households suggest that the demands placed on friends and families have escalated rapidly in the 1980s. The Housing Assistance Council, tracking rural household size from 1979 to 1983, found that:

> . . . the increase in rural working poverty over that period was strongly associated with an increase in household size, not by one or two persons, but by three or more persons. Such large increases, we believe, can only be explained by wide-scale doubling up among working poor families. (Wilson, 1983)

While the inclusion of those with temporary housing in rural areas presents serious methodological problems for researchers, the evidence suggests that there are few alternatives to their inclusion; otherwise, similarly situated urban and rural homeless people would be classified differently.

Second, in some cases the homeless pay nominal rents. One source of housing for the homeless is substandard, seemingly abandoned housing stock. In urban areas, much of this property appears to be commercial or owned by absentee landlords, often enabling the homeless to make use of it virtually unnoticed. The site visits conducted by committee members and the author suggested that these types of dwellings are often located on private property that is either occupied by the owner or adjacent to the owner's property. Because of the increased visibility of transients in rural communities, and the proximity of the property's owner, it was not unusual to see nominal rents imposed on those taking refuge in such dwellings.

Finally, for an individual or family to be considered homeless, the housing arrangement must be temporary or unstable; there must be a need to search constantly for more permanent quarters because of the fear of imminent eviction or displacement. The case outlined above lacks this element of instability; it has served as a family dwelling for more than 20 years.

This appendix thus considers individuals or families as homeless if their housing situation is both unstable and temporary (whether it is in a formal shelter, in a makeshift dwelling, or with friends, without regard for the payment of nominal rent) and they lack the resources to secure adequate housing. It is important to reemphasize that the essential criterion is the instability of the housing arrangement; otherwise, we would simply be redefining the nearly 2 million rural poor who live in substandard housing as homeless, which would not be accurate (Housing Assistance Council, 1984). At the same time, individuals or families awaiting certain eviction in the very near future would be categorized as homeless under this definition.

WHO ARE THE RURAL HOMELESS?

It is predictably difficult to answer this question. The rural homeless are more geographically dispersed and the shelter facilities available in rural areas tend to be small, making it difficult for even shelter operators to categorize the population definitively. We will use two approaches to answer this question: The first is a conceptual framework for classifying the rural homeless; next, we will review the Ohio Mental Health study, which, while limited as a single-state case study, provides the only comprehensive statistical comparison of the rural and urban homeless that has been completed to date.

A useful framework developed by Frank and Streeter (1987) suggests that the rural homeless can be categorized into five distinct groups: (1) the traditional homeless, (2) the new poor, (3) the mentally ill, (4) displaced farmers and farm-related workers, and (5) the new hermits.* This grouping can be examined from two perspectives. In comparison with the urban homeless, the latter two groups (displaced farmers and farm-related workers and new hermits) are unique to rural areas. Another perspective is the extent to which these groups reflect the "new" homeless, whose descent into homelessness is of relatively recent origin. That grouping would primarily include the new poor and displaced farmers and farm-related workers.

The Traditional Homeless

These are the street people similar to many of those seen in urban areas, suffering from substance abuse, personal tragedy, or mental or physical disabilities. They have had little recent attachment to the labor force and have trouble maintaining a permanent address or securing employment. They are predominantly single men.

The New Poor

Driven by financial catastrophe, this category has made the largest contribution to the number of rural homeless in recent years. For the most part, they are the working poor or near poor and are two-parent families with children; in most cases, both parents hold part- or full-time jobs. The combination of the recent recessions and the structural transformation of the rural economy often leaves them with few local employment opportunities. As their meager savings are quickly eroded, they

*This section is drawn directly from the typology of Frank and Streeter (1987, pp. 39–42).

are faced with two equally unpalatable alternatives: move in with friends or travel in search of employment.

Those choosing to move on often find free shelter unavailable and are forced to rely on abandoned dwellings, sleeping with the entire family in their vehicles, or, in warmer climates, camping out. A recent study suggests that the homeless are making use of state and federal campground areas (Mariani, 1987). For example, in one Maricopa County, Arizona, campground, over half of the campers were homeless people in search of jobs. For those choosing to move in temporarily with friends, neighbors, or relatives, the hazards are different: Stress often builds quickly in overcrowded quarters and may result in both psychological and physical abuse (Redburn and Buss, 1987).

The Mentally Ill

The number of chronically mentally ill patients in specific rural communities varies significantly. For the most part, they appear to gravitate toward the larger rural communities or towns within close proximity to state mental hospitals. For example, there appeared to be a substantial chronically mentally ill homeless population in the Minnesota-North Dakota shelters, all of which were within close proximity to state mental hospitals. By contrast, the Alabama and Mississippi site visit identified few chronically mentally ill patients.

Displaced Farmers and Farm-Related Workers

The pace of farm foreclosures has resulted in the displacement of large numbers of farmers and farm-related workers. Social workers dealing with farm families argue strongly that farmers face unique stresses as a result of foreclosure. Foreclosure represents the loss of the family home, the farmer's job and primary social network, and the children's inheritance; if the farm has been in the family for several generations, the guilt and self-recrimination are magnified.

When foreclosures are especially numerous in an area, banks and lending institutions often have trouble reselling the farms quickly. As a result, farm families are often permitted to remain as caretakers on a day-to-day basis with eviction quickly following the final sale of the property. From the point of foreclosure, farmers in this unstable and transient position are essentially homeless under our definition.

The site visits confirmed earlier work (Frank and Streeter, 1987) that farmers seldom make use of the available shelters in the larger rural communities; anecdotal evidence suggests that they rely on friends or relatives in other parts of the county or neighboring counties for temporary

housing. Service providers consistently agreed that this population is greatly in need: marriages dissolve; generations are divided; family abuse rates are up; and alcoholism, stress, depression, and suicide attempts are on the rise (Wall, 1985; Heffernen and Heffernen, 1986).

This group also includes migrant and seasonal farm workers whose housing, health care, and social service needs have never been adequately met by the existing delivery systems, even in the best of times.

The New Hermits

There is a new group of homeless that is small in number. They have sought refuge in the mountains of Arkansas, Oregon, Washington, and West Virginia. Some are "survivalists," Vietnam veterans, "back-to-the-landers," and others who are isolated from mainstream American society.

There are few data about these individuals and little understanding of whether their homelessness is by choice or economic necessity.

THE OHIO STUDY

Statistical data on the rural homeless have not been collected on the national level. The most exhaustive and authoritative effort to date was the 1985 Ohio Mental Health Study (Ohio Department of Mental Health, 1985).* Because the researchers conducted extensive interviews with 790 urban and 189 nonurban homeless people, their survey provides the most extensive data base available on the demographics of the rural homeless and the ways in which they are both similar and different from their urban counterparts.

These data cannot be generalized to the nation. It is, after all, a case study of one state. Despite that limitation, the Ohio study data provide a rich source of information for developing a preliminary sense of the rural homeless.

In categorizing their data, the Ohio researchers looked at three types of counties: urban, rural, and mixed (rural counties adjacent to urban areas). In preparing their summary tables, some of which are reproduced here, most of the data are consolidated into two categories: urban and nonurban (which includes both the rural and mixed counties). When this combination distorts the analysis, the data will be disaggregated. All of the tables in this section have been reproduced from the Ohio study's final reports, although evidence from other studies and the interviews conducted for this paper will also be cited.

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*The tables and analysis are drawn directly from the chapter on urban/nonurban comparisons, Ohio Department of Mental Health (1985, p. 53).

Demographics

Table C-1 provides a summary comparison of the demographics of the urban and nonurban populations interviewed by the Ohio research team. A few highlights are given below.

Sex and Marital Status

Women constitute a much higher proportion of the rural homeless population (32.3 versus 15.8 percent of the urban homeless), a fact that is partly explained by the much higher percentage of rural homeless who are married (18.5 percent of the rural homeless versus 6.7 percent of the urban homeless).

Ethnicity

Ethnicity reflects the demographics of the state and is representative of many Midwestern states, which do not have significant minority populations other than blacks (e.g., Hispanics or Indians).

Age

On average, the rural homeless are a slightly younger population, with 72 percent being under age 40 (versus 60 percent of the urban homeless that are under age 40). These results are parallel to those of a study in Vermont, in which it was found that most homeless are in their early 30s

TABLE C-1 Demographic Comparison of Urban and Nonurban Counties (Ohio Data)

	Urban		Nonurban		Total	
Characteristic	No.	Percent	No.	Percent	No.	Percent
Sex						
Male	665	84.2	128	67.7	793	81.0
Female	125	15.8	61	32.3	186	19.0
Total	790	100.0	189	100.0	979	100.0
Ethnicity						
White	466	59.0	173	91.5	639	65.3
Black	281	35.6	11	5.8	292	29.8
Hispanic	30	3.8	3	1.6	33	3.4
Other	6	0.8	0	0.0	6	0.6
No answer	7	0.9	2	1.0	9	0.9
Total	790	100.1	189	99.9	979	100.0

TABLE C-1 *Continued*

Characteristic	Urban		Nonurban		Total	
	No.	Percent	No.	Percent	No.	Percent
Age (years)						
18–29	250	31.6	90	47.6	340	34.7
30–39	224	28.4	46	24.3	270	27.6
40–49	139	17.6	25	13.2	164	16.8
50–59	115	14.6	15	7.9	130	13.3
≥60	53	6.7	10	5.3	63	6.4
No answer	9	1.1	3	1.6	12	1.2
Total	790	100.0	139	99.9	979	100.0
Education						
No formal schooling	7	0.9	1	0.5	8	0.8
1–8 grades	129	16.3	32	16.9	161	16.4
9–11 grades	291	36.8	73	38.6	364	37.2
High school graduate	241	30.5	57	30.2	298	30.4
Some college	97	12.3	22	11.6	119	12.2
College graduate	19	2.4	3	1.6	22	2.3
No answer	6	0.8	1	0.5	7	0.7
Total	790	100.0	199	99.9	979	100.0
Marital Status						
Married	53	6.7	35	18.5	88	9.0
Separated	114	14.4	21	11.1	135	13.8
Widowed	39	4.9	4	2.1	43	4.4
Divorced	199	25.2	48	25.4	247	25.2
Never been married	366	46.3	72	38.1	438	44.7
Living together	12	1.5	9	4.8	21	2.1
No answer	7	0.9	0	0.0	7	0.7
Total	790	99.9	189	100.0	979	99.9
Veteran status						
Yes	264	33.4	46	24.3	310	31.7
(Vietnam veteran)	(73)	(9.2)	(10)	(5.3)	(83)	(8.5)
No	523	66.2	142	75.1	665	67.9
No answer	3	0.4	1	0.5	4	0.4
Total	790	100.0	189	99.9	979	100.0
Ever been in jail/prison						
Yes	470	59.5	103	54.5	573	58.5
No	313	39.5	85	45.0	398	40.7
No answer	7	0.9	1	0.5	8	0.8
Total	790	100.0	189	100.0	979	100.0

SOURCE: Ohio Department of Mental Health (1985).

(Vermont Department of Human Services, 1985). They also reflect the profile of farmers who have recently lost their land: they are young and well-educated (Brown and Deavers, no date). There are no appreciable differences between urban and rural homeless on education or incarceration.

Military Service

The urban homeless are more likely to have served in the military (33.4 percent) than are their rural counterparts (24.3 percent).

Homelessness

Nearly three-quarters of both the urban and rural respondents had been homeless for less than 1 year (Table C-2). A slightly higher percentage of urban respondents had been homeless for more than 2 years.

Reason for Homelessness

When asked to identify the major cause of their homelessness, both groups overwhelmingly cited economic factors as the most important reason and family problems as the second most important (Table C-3). These responses parallel the available anecdotal and descriptive data from other studies.

TABLE C-2 Length of Time Respondents Were Homeless (Ohio Data)

	Urban		Nonurban		Total	
Time (days)	No.	Percent	No.	Percent	No.	Percent
≤30	308	39.0	73	38.6	381	38.9
31–60	71	9.0	25	13.2	96	9.8
61–365	192	24.3	46	24.3	238	24.3
366–730	50	6.3	17	9.0	67	6.8
≥731	126	16.0	21	11.1	147	15.0
No answer	43	5.4	7	3.7	50	5.1
Total	790	100.0	189	99.9	979	99.9
Mean no. of days	675.9		378.4		617.6	
Median no. of days	60.0		60.0		60.0	

SOURCE: Ohio Department of Mental Health (1985).

TABLE C-3 Reported Major Reason for Homelessness (Ohio Data)

Reason	Urban		Nonurban		Total	
	No.	Percent	No.	Percent	No.	Percent
Unemployment	173	21.9	40	21.2	213	21.7
Problems paying rent	111	14.1	25	13.2	136	13.9
Family conflict	100	12.7	30	15.9	130	13.3
Eviction	74	9.4	20	10.6	94	9.6
Other reasons	70	8.9	22	11.6	92	9.4
Family dissolution	54	6.8	24	12.7	78	8.0
Alcohol/drug abuse	63	8.0	8	4.2	71	7.3
Like to move around	52	6.6	8	4.2	60	6.1
Government benefits stopped	27	3.4	0	0.0	27	2.8
Disaster	20	2.5	4	2.1	24	2.5
Deinstitutionalization	18	2.3	6	3.2	24	2.5
Was in jail/prison	15	1.9	1	0.5	16	1.6
No answer	13	1.5	1	0.5	14	1.4
Total	790	100.1	199	99.9	979	100.1

SOURCE: Ohio Department of Mental Health (1985).

Shelter

The rural homeless are four times more likely to have spent the previous night with family or friends (40.7 versus 10.7 percent for urban homeless), while the urban homeless are far more likely to rely on missions or shelters for lodging (37.1 versus 11.1 percent) (Table C-4). This is one case in which it is helpful to disaggregate the data to look at the use of shelters by the nonurban homeless. As expected, the data confirm that these shelters are most likely located in the urbanized (or mixed) rural communities. In fact, only 20.4 percent of the homeless in these urbanized rural communities used shelters or missions, while none of those in more rural counties had spent a night in these facilities.

Transience

Both the urban and rural homeless do not move as often as one might expect (Table C-5); in fact, over half of both groups spent the previous month in only one or two lodgings.

In Table C-6, there is a striking but not unexpected contrast in the reasons for which the urban and rural homeless moved to the county in which they were interviewed. While 22 percent of the urban homeless

TABLE C-4 Place Respondents Slept the Previous Night (Ohio Data)

	Urban		Nonurban		Total	
Place	No.	Percent	No.	Percent	No.	Percent
Limited or no shelter	238	30.1	50	26.5	288	29.4
No shelter	131	16.6	30	15.9	161	16.4
Car, abandoned building, public facility	107	13.5	20	10.6	127	13.0
Mission, shelter	293	37.1	21	11.1	314	32.1
Cheap motels and hotels	141	17.8	30	15.9	171	17.5
Other	116	14.7	88	46.6	204	20.8
With family	28	3.5	32	16.9	60	6.1
With friends	57	7.2	45	23.8	102	10.4
Unique conditions	31	3.9	11	5.8	42	4.3
No answer	2	0.2	0	0.0	2	0.2
Total	790	99.9	189	100.1	979	100.0

SOURCE: Ohio Department of Mental Health (1985).

came in search of a job, only 8 percent of the rural homeless did so. For the rural homeless, the overwhelming reason (43.7 percent) was to be near friends and relatives (only 19.7 percent of urban homeless gave that response).

Employment

Based on self-reports by nonurban homeless individuals, the findings on employment suggest that they had a more recent attachment to the

TABLE C-5 Number of Places the Homeless Stayed During the Previous Month (Ohio Data)

	Urban		Nonurban		Total	
No. of Places	No.	Percent	No.	Percent	No.	Percent
1–2	453	57.3	106	56.1	559	57.1
3–4	188	23.8	57	30.2	245	25.0
5–6	55	7.0	14	7.4	69	7.0
7–8	17	2.2	3	1.6	20	2.0
>8	50	6.3	7	3.7	57	5.8
No answer	27	3.4	2	1.1	29	3.0
Total	790	100.0	189	100.1	979	99.9
Mean number	3.3		3.1		3.3	
Median number	2.0		2.0		2.0	

SOURCE: Ohio Department of Mental Health (1985).

TABLE C-6 Reason for Nonpermanent Residents Coming to County (Ohio Data)

Reason	Urban		Nonurban		Total	
	No.	Percent	No.	Percent	No.	Percent
To live with relative or friend	90	19.7	59	43.7	149	25.1
To look for a job	101	22.1	11	8.1	112	19.0
Other reasons	63	13.8	24	17.8	87	14.7
Another stop while passing through	48	10.5	13	9.6	61	10.3
To take a job	40	8.8	12	8.9	52	8.8
For public sleeping shelters	30	6.6	3	2.2	33	5.6
Lived here before	25	5.5	9	6.7	34	5.8
For social service programs	8	1.8	1	0.7	9	1.5
To go to school	9	2.0	0	0.0	9	1.5
Heard you could get on welfare	4	0.9	2	1.5	6	1.0
For community kitchens	4	0.9	0	0.0	4	0.7
Less police hassle	2	0.3	0	0.0	2	0.4
No answer	32	7.0	1	0.7	33	5.5
Total	456	100.0	135	99.9	591	100.0

SOURCE: Ohio Department of Mental Health (1985).

labor force and current earnings were a much more important source of revenue for those with any income. Some of the data are summarized below:

- Ever held a job (percentage who held a job at some point)?
  —Urban homeless: 85.9
  —Nonurban homeless: 93.6
- Worked in the last month (percentage who reported working)?
  —Urban homeless: 22.2
  —Nonurban homeless: 35.4
  Mixed county: 42.7
  Rural county: 25.7
- The last year worked for those who have not worked in the previous month (percentage).

—Urban homeless		—Nonurban homeless	
1983–1984:	33.6	1983–1984:	54.5
1978–1982:	38.6	1978–1982:	30.0

- Reason for not working now.

Two major reasons (percentage)	Urban Homeless	Nonurban Homeless
Looked, but cannot find work:	43.9	61.8
Disabled; cannot find work:	21.7	16.4

COUNTING THE HOMELESS

There are no reliable estimates of the number of rural homeless. Few states have even published estimates of the number of rural homeless clients that are served by social service providers. Two that did, California (California Department of Economic Opportunity, 1986) and Maryland, (Maryland Department of Human Resources, 1986) developed identical estimates: 18 percent of the homeless are rural residents.* Despite the striking similarities of the data from these two states, it would be premature to attempt national estimates at this point based on these figures. Service provider estimates are often biased upward as a result of counting the same individual or family twice when they are served by the same provider at different times or by multiple providers. At the same time, it is clear that many aspects of the rural environment contribute to the invisibility of the rural homeless, leading to the potential for underestimates.

First, the problems of enumerating the homeless in the urban area multiply in the vast geographic expanse of rural America. As noted earlier, service providers are seldom found outside the larger rural communities (Redburn and Buss, 1987); therefore, provider-based surveys only tap a portion of the homeless in rural communities. In addition, there are difficult methodological problems in counting those homeless people who are temporarily sheltered with friends, neighbors, and relatives, an issue requiring further empirical work. In addition, as the Ohio study demonstrated, there are difficulties in identifying those rural homeless who are outside of rural communities:

> . . . hermits who live in caves, culverts or lean-tos; mountain people who have had a bad year in a kind of hunting/gathering society; miners who have been laid off; homeless persons who prefer the woods to the streets; and others who have exiled themselves. These homeless people are, in many ways, indistinguishable from mountain or rural people who are poor but not homeless.
>
> Nearly all of these people, the homeless and others alike, appear to have two things in common: they are heavily armed; and they do not like strangers. (Redburn and Buss, 1987)

Second, there is a major perceptual issue regarding the concept of homelessness. The very nature of the informal support system in rural areas leads residents to view homelessness as an attribute of transients and outsiders. Community residents who have lost their farms or homes are constantly referred to as "local folks on hard times," while outsiders or transients are more readily labeled as homeless. To the extent that the local community serves few transients or outsiders, residents generally

*The Ohio data presented here cannot be used to project the number of rural homeless in the state. The rural homeless were oversampled.

do not perceive the fact that homelessness exists in their community. Thus, even surveys that go beyond social service providers to key community leaders can still result in underestimates.

All of these factors converge to make rural homelessness, like rural poverty, difficult to assess and measure. From a public policy perspective, the central question may not be the actual number of rural homeless but the ability of local communities to meet that burden without outside assistance from the federal or state government.

THE RURAL ENVIRONMENT

To understand the ability of rural communities to respond to the growing number of homeless people, it is important to consider aspects of the rural environment that affect both the capability and inclination of rural communities to respond.

The starting point for any discussion of rural America is an examination of the diversity of rural communities; the importance of this diversity cannot be overemphasized. Rural Arizona is a very different place from rural Alabama or rural Minnesota. These differences are far from trivial.

In fact, the National Rural Health Association has identified at least four types of rural communities:

- Adjacent rural areas—contiguous to or within metropolitan statistical areas (MSAs), which are very similar to their urban neighbors;
- Urbanized rural areas—population of 25,000 or more but distant from an MSA;
- Frontier areas—population densities of less than 6 people per square mile; these are the most remote areas; there are no frontier areas east of the Mississippi River; and
- Countryside rural areas—the remainder of the country not covered by urban or rural designations. (Elison, no date)

Both community size and proximity to urban areas have a profound impact on a community's ability to develop and maintain a formal social services network for its residents and the homeless in its midst.

Larger Rural Communities

The larger rural communities generally have a broader economic base and a more formalized social services network (Ohio Department of Mental Health, 1985); the bulk of rural shelters and community kitchens appear to be located in these communities (Redburn and Buss, 1987). While many of the poorer or more remote rural communities face serious obstacles in attracting sufficient numbers of health care providers, there

is less of a problem in larger communities. During the site visits to these communities, the committee found shelters that generally had direct access to health care professionals or that encouraged their residents to secure health care, through federal programs or Medicaid or other state programs, as quickly as possible.

A number of observations regarding these communities can be made as a result of the site visits. First, demand for overnight and emergency shelters clearly outstripped the supply, as did requests to the local food pantries. Many shelters were operating at capacity; in fact, one shelter was licensed for 10 residents but was housing 25 residents at the time of the site visit. Community Action Agency staff often reported that their annual budget for the provision of emergency housing services was depleted in the first 2 to 3 months of the fiscal year. Similarly, social service organizations often found that their monthly funds for housing vouchers were exhausted early in the month.

Second, there were few facilities that could accommodate an intact family, and fewer still that could accept underage youths.

Third, despite the obvious distress in the local farm economy, few displaced farmers or farmhands made use of these shelters. Future research needs to focus on what happens to these farmers and farmhands following foreclosure and what support services, if any, they actually utilize.

Finally, shelter staff, homeless advocates, and the social service community were quite innovative in their approach to problems. A few examples follow.

- Tired of finding chronically mentally ill patients on his doorstep without warning, the director of one center has succeeded in enlisting the cooperation of one of the state mental hospitals in an effort to work together to plan for a patient's discharge. He is now trying to elicit the cooperation of the other major state mental hospital.
- In an effort to develop a more effective long-term intervention strategy, the development of transitional housing was moving ahead with surprising speed in Minnesota. Transitional housing provides a more permanent living environment (generally up to 6 months) for those homeless individuals capable of living independently, facilitating job search and reentry into the community.
- The Dorothy Day House in Minnesota also has begun operation of a farm in an effort to develop a place where the "burnt out" homeless, consumed by the daily struggle for survival, could have several months in a peaceful, remote setting to renew themselves.
- An innovative peer counseling program was developed for farmers

by a Catholic Charities family service agency in an effort to break the self-imposed isolation of troubled farm families. To encourage participation, they ensured anonymity for farmers seeking counseling by drawing their counselors from farm families on the other side of the county. A secondary aim of the program was to provide financial assistance to the farmers and counselors, who were well reimbursed for their time.

Smaller Rural Communities

Smaller rural communities seldom have a formal social services system. Instead, they have a highly developed informal referral network among the leading members of the community that can be mobilized to assist community residents in need. Transients requiring assistance present an entirely different situation; they are often given short shrift. They are highly visible strangers and are generally viewed with suspicion. As the Ohio researchers discovered, rural leaders

> . . . perceive their systems to be targeted almost exclusively to local homeless residents as opposed to transients or outsiders. Transients or outsiders are usually encouraged, often by force, to move on to urban areas. This is accomplished by providing bus fare to the nearest city, arresting persons until deportation can be executed, "rousting" persons from public and private places, and offering or providing few, if any, helping services. Non-urban places are hostile to homeless outsiders. (Ohio Department of Mental Health, 1985)

Yet there are growing indications, found both during the site visits and in the literature, that these communities are not always mobilizing to support neighbors in financial distress as they have in the past. This was most evident in the farming communities. Farmers have always been an independent group, and usually are quite unwilling to ask for assistance. In the past, such a request never had to be made: neighbors simply showed up to help. That spirit of rural cooperation is best typified by the traditional barn raising.

While farmers still believe that their neighbors will assist them in the event of death or natural catastrophe, the farmers who had recently faced foreclosure did so alone. During the site visit to Minnesota, farmers spoke bitterly of the decline of the old rural ethic that "we take care of our own." Their stories echoed a recent *Wall Street Journal* article, in which troubled farm families claimed that they were "shunned in church, taunted in schools and often subsisting on skimpy meals" (Wall, 1985).

Farmers attributed this change in attitude to a number of factors. Over the last two decades changing farm technology has eliminated the need for collective efforts such as group harvesting. Farms have become more

insulated from each other; they are becoming more of a business than a neighborly family operation. There is a new prevailing attitude: if a neighbor is in trouble, it must be his or her own fault for becoming financially overextended. Perhaps more important, the farm crisis is so pervasive that many neighbors are barely able to maintain subsistence and have little to share. A study of 40 families forced out of farming in Missouri confirms impressions from the Minnesota site visit that there is a "surprising lack of support reportedly provided these families by their communities" (Heffernan and Heffernan, 1986). The fraying of the social support fabric in these rural communities could have important implications for the rate at which financially troubled families descend into homelessness.

Farm families also singled out the food stamp program as an example of the failure of publicly funded income support programs to prevent this downward spiral. They were convinced that timely assistance from existing programs could have prevented many farm families from entering the ranks of the homeless, and were particularly bitter at the failure of public officials to recognize how the eligibility criteria for these programs systematically disqualified farm families.

Inadequate Housing

The U.S. Department of Housing and Urban Development has estimated that in 1983, 840,000 members of very-low-income rural households were living in "severely inadequate" housing; members of another million very-low-income households were living in houses that were merely "inadequate" (Wilson, 1983).*

Adequate affordable housing was a major issue in all of the states that the committee visited. While there was an extensive series of subsidized and public housing projects in the rural towns in the South, they were not sufficient to meet the demand, and waiting lists often stretched for years. As a result, many local residents were forced to live in extremely substandard dwellings, essentially, broken-down shacks, for which most paid a rent of $25 per month. A few had indoor plumbing; most did not. A few more had an outdoor privy; at least half of these shacks lacked even a privy.

In Minnesota, substandard, low-cost housing of the type seen in southern states could not be found. Displaced farmers and rural workers faced a different dilemma: rental rates two to three times the level they had paid in their smaller communities.

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*The U.S. Department of Housing and Urban Development defines very-low-income households as those with incomes below 50 percent of the area median.

Transportation

Transportation remains one of the greatest barriers to access for rural health and social services as well as employment opportunities. The problem can be measured both in distance and travel time. It is further complicated by unpredictable weather, which can make travel both risky and inefficient.

While states such as Alabama have a strong outreach program through their child protective service and public health nurse program, access to physician services, even when free, is often thwarted by transportation barriers. During the Alabama site visit, many of the rural poor noted that their neighbors charged them $10 to $20 for a ride to the local health clinic. That nearly equalled a month's rent for many of these families and made such trips prohibitively expensive, unless there was a true emergency.

Homeless people served by some community health care centers, such as the one in Mound Bayou, Mississippi, are more fortunate. The health care center is able to provide bus service throughout the rural counties. Once again, however, the cost in time to those being served appears high. The bus follows a fixed route, meaning that for some clinic users, a routine visit consumes an entire day: a several-mile walk to and from the bus stop; a bus ride that might take as long as 2 hours each way, and the time at the clinic.

Transportation barriers also discourage participation in vital nutrition assistance programs such as food stamps. A recent report by the Food Research and Action Council noted that:

> A total of 40 Texas counties, more than 15% of those in the state, do not have a food stamp office. . . . [C]onsequently, some persons may have to travel upwards of 50 miles to apply for public assistance benefits.
>
> Clients receiving $10 to $15 in food stamps sometimes have to pay that much to get to the office.
>
> (Or in Arkansas): Many persons have to pay someone to drive them [on] a 100 mile round trip only to be refused to be seen if they are 15 minutes late. (Food Research and Action Council, 1987)

HEALTH CARE RESOURCES

In the last three decades, a number of federal initiatives were designed to increase the accessibility of health care in rural areas: the national Hill-Burton Hospital Construction Program, the establishment of community mental health centers and community and migrant health centers in underserved areas, and the development of the National Health Service Corps. While access to care has clearly improved for many rural residents, it remains problematic for many others.

There are a number of barriers to access that remain, the most prominent of which is financial. The majority of rural poor live in intact families, but the states in which they live generally do not extend Medicaid eligibility to intact two-parent families and set eligibility levels for single mothers at a fraction of the federal poverty level. Because of the preponderance of minimum wage jobs in the service sector that have few benefits, the working poor are also less likely to be insured. Insurance is often unaffordable: Premiums on individual policies are high and must be paid without the benefit of either a contribution by the employer or the tax subsidy of employment-based insurance.

Even when families have health insurance, financial barriers may remain. A recent survey of financially distressed rural Minnesota farm families indicated that while most farm families struggled to retain their health insurance coverage as their economic situation deteriorated, they had been forced to maintain a high deductible rate and curtail their use of discretionary preventive care, such as mammograms or Pap smears (Southern Minnesota Family Farm Fund, 1986).

As a result, unforeseen emergency care may have the double impact of providing the financial push from poverty to homelessness for rural residents, depleting the family's remaining resources, and, at the same time, effectively divorcing the family from future access to care. The adequacy of Medicaid coverage for the poor and near poor is a major issue in preventing homelessness and ensuring continuing care should homelessness occur for other reasons.

Another barrier is limited provider availability. Rural areas attract fewer health care providers: Salaries are lower, as are third-party insurance reimbursement levels; there are fewer professional support systems or health care facilities; and, there is less potential for continuing education. David Kindig of the University of Wisconsin recently reported that the level of physician availability for counties with populations of less than 10,000 is one-third the national average, the growth of physician availability in rural areas over the last decade (14.2 percent) was significantly less than that in the nation as a whole (32.5 percent), and in general, smaller counties have lower physician availability (Kindig and Movassaghi, 1987).

Other traditional sources of care are in transition. Rural hospitals have faced more significant declines in admissions, patient length of stay, and occupancy rates than their urban counterparts, while they have experienced reimbursement constraints from Medicare and other insurers (Congressional Research Service, 1986). The results have been an increase in the number of closures of rural hospitals and a declining financial situation for many rural hospitals, severely limiting their ability to provide uncompensated care.

The resources of community health centers, the primary source of health care for many of the rural poor, have been limited by declining federal resources throughout the economic recession of the 1980s. With increased need and fewer dollars, community health centers have been prodded by federal officials to expand both the number of private pay patients they see and the amount of private pay collections in an effort to broaden their resource base. While marketing to paying clients was intended to bring in the necessary revenue to continue outreach services to the underserved and to subsidize services to the centers' poorer clients, such efforts have not always been successful. In addition, in areas such as dental care, budget constraints appear to be replacing curative work with lower cost prevention efforts.

At the same time that access to health resources is constrained, the rural poor and homeless often appear to face greater health risks. As the site visit to Alabama's Black Belt demonstrated, rural poverty itself can pose a grave environmental threat to health. Substandard housing lacking insulation or even a privy increases the risk of contaminated water supplies, the spread of infectious diseases, and accidents. In such an environment, it is often impossible to maintain proper nutrition; storage and preparation of foods are hindered by the conditions of these shacks and of the major appliances; and early childhood development is retarded by the lack of intellectual stimulation and the inability to develop a sense of self-esteem. As in the urban ghetto, the limited funds available to these families to purchase a balanced diet are eroded even further by an inability to travel to grocery stores that have lower prices.

Health Care for the Homeless

The U.S. Department of Health and Human Services (HHS), in support of this appendix, recently asked its 10 regional offices to survey their community and migrant health center grantees serving rural populations to determine the utilization of health services by the homeless. While all of the regional reports are not yet available, the report from the Chicago Region V office (covering Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin) provides the most comprehensive data of those now available (C. Tavani, personal communication).

These results must be viewed with some caution. The survey was not scientific. In responding to this survey, centers did not conduct a comprehensive review of their caseload in an attempt to identify the homeless and their health care problems. Thus, the possibility of undercounting the homeless is high. Community health centers do not regularly attempt to identify whether patients are homeless. In fact, most patients generally provide the centers' staff with an address when asked, even if

they provide an out-of-date or fictional address or the address of a friend or relative.

Of the 36 community and migrant health centers surveyed in the Midwest, 29 reported that they had served homeless patients (Table C-7) during the previous year. With a range from 4 to 120 patients per year, the median annual number of homeless patients served was 25.

The major health problems of the rural homeless are identified in Table C-8. Acute and episodic illnesses (including colds, upper respiratory disturbances, gastrointestinal disturbances, and dermatological problems) and malnutrition lead the list. Reports from other regional offices (not presented here) suggest the importance of substance abuse and mental health needs; these problems were highlighted during the site visits. The use of alternative service providers, such as detoxification centers, may be an important factor in the lower frequency of substance abuse reported here. Regarding mental health services, even in the larger rural communities, access to mental health professionals is limited for indigent populations. The extremely large catchment areas for community mental health centers and the limited resources for treating a diverse rural population pose severe access barriers.

The site visits also highlighted a tremendous need for curative dental services among the rural homeless and poor. In most cases, preventive care was of little value to these individuals. To the extent that community health centers have been forced by budget constraints to emphasize preventive care over curative dental services, the frequency reflected in Table C-8 may be artificially low.

Table C-9 highlights the type of services received by the rural homeless. In addition to primary care, additional services were provided to the homeless either on site or by referral. The social services category includes temporary shelter, clothing, food, emergency welfare, the special

TABLE C-7 Estimated Number of Homeless Served by Health Center (Chicago HHS Region V Data)

	Ill.	Ind.	Mich.	Minn.	Ohio	Wis.	Total
Median	28	100	25	63	31	6	25
Range							
Low	4		5	25	12	4	4
High	47		50	100	120	40	120
No. of centers	6	1	11	2	6	3	29

SOURCE: C. Tavani, Office of Planning, Evaluation, and Legislation, Health Resources and Services Administration, U.S. Department of Health and Human Services, Washington, D.C. Personal communication.

TABLE C-8 Major Health Problems of the Rural Homeless (Chicago HHS Region V Data)

Problem	Frequency in:						
	Ill.	Ind.	Mich.	Minn.	Ohio	Wis.	Total
Acute/episodic illness[a]	6	1	9	1	3	2	22
Malnutrition	5	1	9	2	4	1	22
Alcoholism/drug abuse	1	1	3	1	3	1	10
Emergency	2		4	1	2	1	10
Dental	2		4		1	1	8
Mental health	1	1	2	1	2		7
Chronic illness[b]	1		3	1	1		6
Hypothermia/overexposure	1	1	1	1	1		5
Maternity/obstetrics/gynecology	2		2		1		5
Hygiene/sanitation	1		2				3
Seek pain medication			1			1	2
Other[c]			2		1		3

[a]Includes upper respiratory, gastrointestinal, dermatological, and similar disturbances.
[b]Includes diabetes, cardiovascular, hypertensive, arthritic, and similar disturbances.
[c]Includes general malaise, neglected medical attention, and similar conditions.

SOURCE: C. Tavani, Office of Planning, Evaluation, and Legislation, Health Resources and Services Administration, U.S. Department of Health and Human Services, Washington, D.C. Personal communication.

supplemental food program for Women, Infants, and Children (WIC), and similar services. The frequency of nutritional counseling attests to the importance of nutrition as a health risk factor in this population.

THE OHIO MENTAL HEALTH STUDY

Unfortunately, the data presented above do not permit a comparison with the urban homeless population; for such a comparison, the only source of statistical data, once again, is the Ohio Mental Health Study.

Health Status

The Ohio Mental Health Study asked the homeless to identify their physical health problems; the answers are presented in Table C-10. Overall, 30.7 percent of respondents reported a current medical problem; no striking differences emerged from the data for the urban and nonurban homeless. The differences between this list and the one presented by the Chicago Region V office in Table C-8 may reflect reporting bias; these

TABLE C-9 Services Provided to Rural Homeless (Chicago HHS Region V Data)

Type of Service	Frequency of Response						
	Ill.	Ind.	Mich.	Minn.	Ohio	Wis.	Total
Primary care	5	1	11	2	6	2	27
Social services	3	1	6	1	5	2	18
Nutrition	5	1	5	1	2		14
Dental	1		4	1	1		7
Health education	1		1	2	2		6
Transportation	1		2	1	2		6
Pharmacy	2		2	1	1		6
Specialized medical care	1		1		1	1	4
Mental health		1	2		1		4
Translation	1			1		1	3
Substance abuse						1	1

SOURCE: C. Tavani, Office of Planning, Evaluation, and Legislation, Health Resources and Services Administration, U.S. Department of Health and Human Services, Washington, D.C. Personal communication.

data are based on self-reports; the Midwest data are based on provider recall. There were no data available on the rural homeless based on chart review or actual patient exams. The limitations of self-reporting are best demonstrated by the limited recognition by the rural homeless that they face dental problems. Health care providers and the site visits substantiated that dental problems are among the most significant of the unmet health care needs of the rural homeless.

An interesting finding resulted when the data for the nonurban group were disaggregated into a rural county category and a mixed (urbanized rural) county category. Significant differences emerged in the overall rate of reported illness: In comparison with 31 percent of the urban homeless who reported a health problem, the mixed (urbanized rural) county rate was 20.4 percent while the rate for rural homeless was 41 percent. Unfortunately, a table disaggregating the specific health problems was not available. One possible explanation for the higher rural rate would be the very high accident rate in farming that might leave former farm laborers with residual chronic problems.

Emergency Room Utilization

The overall rate of emergency room utilization by the homeless was only slightly higher than that for the general population (Table C-11). In

1984 Redburn and Buss (1987) reported that 23 percent of the adult population in Ohio reported that they had been to an emergency room in the previous year, compared with 25 percent of the homeless overall.

Table C-11 shows that the nonurban homeless use emergency rooms at a slightly higher rate (29.6 percent); the urban homeless use emergency rooms at a level closer to that for the general population (23 percent).

Despite the lack of alternative primary care providers, the voluntary use of emergency rooms may actually be far lower than these numbers suggest. Very often emergency room visits are instigated by local

TABLE C-10 Physical Health Problems Identified by Homeless People (Ohio Data)

	Urban		Nonurban		Total	
Problem	No.	Percent	No.	Percent	No.	Percent
Reported no physical problems	536	67.8	133	70.4	669	68.3
Reported physical problems	245	31.0	56	29.6	301	30.7
Ill-defined conditions	70	8.9	19	10.0	89	9.1
Arthritis, rheumatism, and other diseases of the musculoskeletal system	38	4.8	11	5.8	49	5.0
Injury and poisoning	38	4.8	4	2.1	42	4.3
Diseases of the heart and circulatory system	33	4.2	5	2.6	38	3.9
Diseases of the nervous system and sense organs	27	3.4	7	3.7	34	3.5
Diseases of the respiratory system	24	3.0	6	3.2	30	3.1
Diseases of the digestive system	21	2.7	7	3.7	28	2.9
Eye problems	18	2.3	4	2.1	22	2.2
Endocrine and nutritional disorders	14	1.8	4	2.1	18	1.8
Dental problems	14	1.8	2	1.0	16	1.6
Infections and parasitic disorders	8	1.0	3	1.6	11	1.1
Neoplasms (cancer and benign tumors)	7	0.9	3	1.6	10	1.0
Diseases of the genitourinary system	6	0.7	4	2.1	10	1.0
Pregnancy	6	0.7	3	1.6	9	0.9
Diseases of the blood	6	0.7	2	1.0	8	0.8
Alcoholism	6	0.7	0	0.0	6	0.6
Diseases of the skin	4	0.5	0	0.0	4	0.4
No answer	2	0.2	2	1.0	4	0.4
No answer	9	1.1	0	0.0	9	0.9
Total	790	100.0	189	100.0	979	99.9

NOTE: Subtotals for types of problems do not add to the values for "Reported physical problems" because 127 respondents indicated they had two problems.

SOURCE: Ohio Department of Mental Health (1985).

TABLE C-11 Social Service Usage by Homeless People (Ohio Data)

Social Service	Urban		Nonurban		Total	
	No.	Percent	No.	Percent	No.	Percent
Community kitchens	531	67.2	64	33.8	595	60.8
Shelters	506	64.0	46	24.3	552	56.4
Welfare/general relief	319	40.4	116	61.4	435	44.4
Hospital emergency rooms	184	23.3	56	29.6	240	24.5
Shelters for battered women	21	18.6	2	4.0	23	12.4
Community mental health centers	91	11.5	28	14.8	119	12.2

SOURCE: Ohio Department of Mental Health (1985).

authorities if a homeless person is arrested for drunkenness, substance abuse, or loss of emotional control (Redburn and Buss, 1987). The decision to take the person to the emergency room is often a pragmatic move in an effort to limit the potential liability of the authorities in these cases if anything should go wrong.

More often than not, the homeless only use the health care system at times of mental or physical health crisis.

Psychiatric Hospitalization

The number of homeless people in Ohio that have been deinstitutionalized does not reflect the previous high estimates of the deinstitutionalized identified in earlier studies. For both the urban and rural homeless, 3 out of 10 were hospitalized for emotional or mental health problems at some point in their lives (Table C-12).

The Ohio study concluded that the urban homeless "exhibit rates of psychiatric symptoms similar to the rural homeless but show higher rates of behavioral disturbance" (Redburn and Buss, 1987).

Alcohol Abuse

As much as one-third of the total homeless population has problems with alcohol or drugs. The available data (Tables C-13 and C-14) suggest that alcoholism poses a larger problem for the urban homeless. Twice as many urban homeless reported that they drank a lot during the previous month (21.3 percent for the urban homeless versus 10.6 percent for the nonurban homeless). In addition, nearly 3 out of 10 urban homeless reported that they had sought help for their alcoholism, compared with 20.1 percent of the nonurban homeless population.

TABLE C-12 Psychiatric Hospitalization Reported by Homeless People (Ohio Data)

	Urban		Nonurban		Total	
Hospitalization	No.	Percent	No.	Percent	No.	Percent
Never been hospitalized	536	67.8	137	72.5	673	68.7
Been hospitalized[a]	242	30.6	51	27.0	293	29.9
Veteran's hospital	55	7.0	5	2.6	60	6.1
General hospital	100	12.7	29	15.3	129	13.2
State hospital	155	19.6	25	13.2	180	18.4
No answer	12	1.5	1	0.5	13	1.3
Total	790	99.9	189	100.0	979	99.9

[a]Hospitalized subtotals do not add to the percentages listed as "Been hospitalized" because some respondents had hospitalizations in more than one type of setting.

SOURCE: Ohio Department of Mental Health (1985).

TABLE C-13 Reported Drinking by Homeless People During the Previous Month (Ohio Data)

	Urban		Nonurban		Total	
Amount of Drinking	No.	Percent	No.	Percent	No.	Percent
Some	349	44.2	92	48.7	441	45.0
A lot	168	21.3	20	10.6	188	19.2
Not at all	268	33.9	77	40.7	345	35.2
No answer	5	0.6	0	0.0	5	0.5
Total	790	100.0	189	100.0	979	99.9

NOTE: Urban (28.1 percent) homeless people were somewhat more likely to report seeking help for a drinking problem than were nonurban people (20.1 percent). This may be the result of service availability in urban versus nonurban areas.

SOURCE: Ohio Department of Mental Health (1985).

TABLE C-14 Reported Seeking Help for Drinking by Homeless People (Ohio Data)

Behavior	No.	Percent of Total
Have ever sought help	260	26.6
Have not sought help	693	70.8
No answer	26	2.7
Total	979	100.1

SOURCE: Ohio Department of Mental Health (1985).

General Well-Being

Tables C-15 and C-16 suggest that the homeless population has a far more optimistic self-evaluation than might be expected. A large percentage rate their outlook positively, and nearly a third of both groups described their lives as satisfying. There are no significant differences between the two groups on these measures.

Overall, the available data and the site visits suggest that the health care needs of the rural homeless are not significantly different from those of their urban counterparts. It is important to reemphasize, however, that the existing data base is quite meager.

The major health care problems among the adult population are malnutrition, alcoholism and substance abuse, dental care, respiratory illness, stress, depression, mental illness, and environmental health problems such as those related to impure drinking water.

While there is little continuity of care, access to acute health care services seems adequate if there is a pressing physical health problem. Routine or preventive care services are seldom sought because of significant barriers to access, shame, or hostility toward the health care system.

Access to mental health professionals is different, however. Not only are services limited but there is every indication that there is an unmet need for such services among the chronically mentally ill and specific homeless groups, such as farmers. The chronically mentally ill often have trouble accessing the available resources; in general, farmers will not or cannot utilize the available resources because of strong conservative cultural forces (McCormick, 1987). Among teenagers, venereal disease and pregnancy are the two major health issues; little prenatal care is

TABLE C-15 Self-Ratings by Homeless People of Their Nerves, Spirits, Outlook, or Mental Health at Present (Ohio Data)

	Urban		Nonurban		Total	
Response	No.	Percent	No.	Percent	No.	Percent
Excellent	77	9.7	13	6.9	90	9.2
Good	239	30.2	66	34.9	305	31.2
Fair	274	34.7	64	33.9	338	34.5
Poor	125	15.8	27	14.3	152	15.5
Very bad	60	7.6	17	9.0	77	7.9
No answer	15	1.9	2	1.1	17	1.7
Total	790	99.9	189	100.1	979	99.9

SOURCE: Ohio Department of Mental Health (1985).

TABLE C-16 Self-Ratings by Homeless People of Their Satisfaction with Life (Ohio Data)

	Urban		Nonurban		Total	
Response	No.	Percent	No.	Percent	No.	Percent
Very satisfying	80	10.1	16	8.5	96	9.8
Somewhat satisfying	189	23.9	43	22.7	232	23.7
Mixed	282	35.7	78	41.3	360	36.8
Not very satisfying	161	20.4	35	18.5	196	20.0
Not at all satisfying	63	8.0	16	8.5	79	8.1
No answer	15	1.9	1	0.5	16	1.6
Total	790	100.0	189	100.0	979	100.0

SOURCE: Ohio Department of Mental Health (1985).

provided in the South until the final trimester. As in other areas, the malpractice crisis has limited the number of physicians willing to handle obstetrical cases.

Children suffer from malnutrition and failure to thrive, and are at serious risk of accidents, particularly those living in substandard dwellings. They also fail to receive the necessary preventive care. The consequences of this can be devastating.

The depression, stress, and suicidal tendencies among the farm population warrant special outreach efforts in the view of most of our key informants. They strongly suggest that suicides in the farm community are deliberately misreported by the families to save face, that spouse and child abuse rates are rising in this population group, and that alcoholism is increasing. Senator David Durenberger's report of trends in services in southwestern Minnesota may be indicative: according to the senator, a mental health worker in that region stated that between 1983 and 1985 her center experienced a 330 percent increase in the number of people using the 24-hour crisis line and a 30 percent increase in the number of outpatient mental health services (U.S. Congress, Senate, Committee on Finance, 1986).

Teenagers who live on farms appear to be having a particularly rough time. In some cases, their entire lives are preordained: First, they become members of 4-H and Future Farmers of America, and subsequently, they take over the family farm. Now their inheritance and their future are gone, often resulting in resentment and the blaming of their parents for mismanagement. In a small town in North Dakota there were 14 suicides of people living on farms in 14 months, and teenage alcoholism is rising rapidly. In Nebraska one minister reported a tripling in the number of suicide calls he had received over the previous year. In Iowa, Youth and

Shelter Services reported a sharp jump in rural teenage runaways (Wall, 1985).

Another group, while small in number, appears to need additional attention: rural veterans. While most veterans gravitate toward urban areas where Veterans Administration services are more plentiful, veterans remain visible in rural areas and in great need of additional support and counseling. A study of the homeless in Vermont found "homeless veterans who seem to be making rounds from V.A. hospital to V.A. hospital around New England" (Vermont Department of Human Services, 1985).

CONCLUSION

The continuing rural economic crisis ensures that homelessness will remain a problem in rural America. For the most part, it is the working poor and farm families who are the newest rural homeless. Compared with their urban counterparts, they are younger; live in intact, two-parent, two-worker families; and have strong ties to their local community but few economic prospects. They disproportionately live in states that discriminate against intact families in their assistance programs and in communities dominated by a single industry in distress, where their only alternative is a minimum wage, service sector job.

They often face two equally unpleasant options: moving in with friends or relatives or moving in search of employment. In either case, in the long term, they are plagued by the lack of low-cost, affordable housing. Even when subsidized public housing is available, it is generally in the larger rural towns and seldom in the smaller communities that many rural homeless would prefer. Regardless of location, waiting lists for subsidized housing can stretch for years.

The health status of the rural homeless and their utilization of services do not appear to be significantly different from those for the urban homeless. Malnutrition, alcoholism and substance abuse, dental problems, stress, depression, and mental illness are pervasive. Many infants and children suffer from a failure to thrive, malnutrition, and accidents, while teenagers also face high rates of venereal disease and pregnancy, often without the benefit of prenatal care.

In times of emergency, access to physical health care appears adequate. By contrast, routine or preventive care services are seldom sought because of significant barriers to access, shame, or hostility toward the health care system.

Because of the importance of overcoming barriers to routine and preventive care, outreach efforts by community health centers would appear to be critical. As one HHS regional administrator noted, com-

munity health centers are the "backbone" of the health care delivery system in the poorest counties. Yet, the centers are being pushed in what appears to be incompatible directions. The long-term strategy of increasing their income from paying patients appears to be difficult to reconcile with the centers' original mission of meeting the needs of the poor and underserved.

The dramatic changes now taking place in farming communities, particularly within the families of financially distressed farmers, are reminiscent of the self-blame, depression, and suicidal tendencies seen in the 1930s. Farm communities seem to be splintering, providing little sympathy or support for neighbors in economic distress. These farm families then tend to turn inward, using few support services such as shelters or mental health networks. Enhanced outreach efforts such as those provided by the Agriculture Extension Service, child protection, workers, or innovative programs such as the peer counseling program cited earlier appear warranted in an effort to break this unhealthy, self-imposed isolation.

State mental health institutions in rural areas have recently begun to cooperate more extensively with community shelters that accept the chronically mentally ill. Simple efforts at coordinating discharge planning can be of great importance, as demonstrated by the Fargo, North Dakota, shelter.

In the course of site visits, a number of homeless farm families communicated their belief that income support programs—in particular, food stamps—used eligibility criteria that systematically disqualified farmers from receiving timely assistance that might have forestalled their descent into homelessness. Several social workers affirmed this claim. This suggests that there is a need for a systematic assessment of food stamp and other income support programs to determine whether better targeting of these existing programs could serve as an important preventive measure.

Finally, there is a need for additional research on the rural homeless and their health care needs. Two reports that are now under way may be helpful. The Housing Assistance Council is conducting a survey of community action agencies that have been active in working with the rural homeless. The National Coalition for the Homeless is also at work on a report on rural homelessness in the South and is conducting more extensive site visits than those used to prepare this appendix. Both studies should be available in the fall of 1988.

A more systematic assessment of the health care needs of the rural homeless in areas served by the federally funded community and migrant health centers would appear to be a logical starting point for future data collection.

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